

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 04/12/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966353	(X3) DATE SURVEY COMPLETED R 03/30/2017
NAME OF PROVIDER OR SUPPLIER VILLAS AT SUNSET BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 7423 KAUAI LOOP NEW PORT RICHEY, FL 34653	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

A 2nd revisit to the complaint surveys, (CCR# 2016014029 and CCR# 2016012639) was conducted at Villas at Sunset Bay on . Villas at Sunset Bay, Assisted Living Facility, had uncorrected deficiencies and a new deficiency at the time of the visit.

(License # 10594)

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation and interview the facility failed to ensure that unlicensed staff were properly assisting Residents with Medication (Med) self-administration for one Resident (#1) out of three sampled Residents during an observation of a Med pass for assistance with Med Self-Administration.

Findings included:

During a Med pass observation conducted on at 09:40 am an unlicensed staff (Staff A), was witnessed instilling/administering (versus assisting) eye drops () into Resident #1's eyes.

During a brief interview with Staff A on at 09:45am it was confirmed that "this is how I always give him his eye drops."

During a brief interview with the Health and Wellness Director on at 11:51am it was revealed that "They (referring to Med Techs) don't instill eye drops; they should be calling the nurse." The Health and Wellness Director stated that the facility just held an in-service with all of the Med Techs on this.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review, the facility failed to ensure that Electronic

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Medication (Med) Observation Records (EMORs) were accurate and free from omissions and errors for two Residents (#2 and #4) of three sampled residents. Findings included: During a Med pass observation conducted on _____ at 09:55am, a discrepancy was noted for Resident #2's Med: _____ 10mg capsule. The Med _____ pack indicated: take one cap by mouth once daily; the EMOR indicated: take one cap by mouth; the frequency was missing on the EMOR. During a brief interview with Staff B on _____ at 10:00am it was confirmed that the medication assistant was unable to explain how often to give Med (_____) according to the EMOR and knew of the discrepancy and stated, "I just go by the bubble pack." During a brief interview with the Health and Wellness Director, on _____ at 11:51am it was revealed that the procedure for any discrepancy is to get it clarified as the Health and Wellness Director stated, "Whenever a discrepancy is found, the discrepancy is clarified with the nurse and the nurse will clarify it with the doctor." During a random observation on _____ at 12:19pm, Resident #4 was seen wearing _____ . Resident #4 stated that "I wear it (referring to the _____) all the time, every day." A MOR review conducted on _____ found Resident #4 to have _____ ordered 'as needed.' There were no initials found on the MOR (copy attached) indicating Resident #4 uses the _____ on a daily basis. A brief interview with the Health and Wellness Director on _____ at 12:45pm confirmed that Resident #4 "uses the _____ every day." Health and Wellness Director unable to explain the omission in documentation of the _____ daily use. Class III 0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC Based on interview and record review, the facility failed to ensure that prescriptions for residents who receive assistance with self-administration were filled/refilled in a timely manner for three Residents (#2,		

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#4, and #5) of three sampled residents. Findings included: A review of Medication (Med) Observation Record (MOR) conducted on _____ for Resident #2 revealed that several medications throughout the month of _____ had not been given as ordered related to the documented reason 'Not Available'. A review of Medication (Med) Observation Record (MOR) on _____ for Resident #4 revealed that several medications throughout the month of _____ had not been given as ordered related to the documented reason 'Not Available'. A review of Medication (Med) Observation Record (MOR) on _____ for Resident #5 revealed that several medications throughout the month of _____ had not been given as ordered related to the documented reason 'Not Available'. A brief interview conducted on _____ at 11:44am with the Health and Wellness Director revealed that medication assistants and nurses should be pulling the reorder sticker when there are between 7 - 10 pills left in the _____ pack. The reorder sticker is then sent to the pharmacy; The Health and Wellness Director acknowledged "various reasons why Meds are undelivered; it could be order issues or hold-ups with the doctor and if the VA (Veteran's Affairs) takes longer; and, we run into issues with Hospice related to Meds being delivered." Unable to clarify if any of the aforementioned reasons as to why Meds would not be available occurred for missing Med doses for the month of _____ for Residents #2, #4, and #5. Class III 0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC Based on observation and interview the facility failed to ensure that unlicensed staff were properly assisting Residents with Medication (Med) self-administration for one Resident (#1) out of three sampled Residents during an observation of a Med pass for assistance with Med Self-Administration. Findings included:		

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During a Med pass observation conducted on at 09:40 am an unlicensed staff (Staff A), was witnessed instilling/administering (versus assisting) eye drops (.....) into Resident #1's eyes. During a brief interview with Staff A on at 09:45am it was confirmed that "this is how I always give him his eye drops." During a brief interview with the Health and Wellness Director on at 11:51am it was revealed that "They (referring to Med Techs) don't instill eye drops; they should be calling the nurse." The Health and Wellness Director stated that the facility just held an in-service with all of the Med Techs on this. Based on the above stated uncorrected deficiency (relative to complaint CCR 2016014029 and revisits conducted on and), the facility shall be required to employ the consultant services of a licensed pharmacist or a registered nurse. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the Agency determines that such consultation services are no longer required. This serves as a written notification of the requirement for the above described consultation services. Class III		